MEDI-CAL UPDATE Part 2
Billing and Policy
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Inpatient Services

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Contents

2005 CPT-4/HCPCS Updates: Implementation November 1, 2005

The 2005 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2005. Specific policy changes are highlighted below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

SURGERY

Duplicate Payment: Combination Codes

Reimbursement will be made for only one code or set of codes in the following combinations when billed for the same date of service, any provider:

- G0364 vs. 38220 – 38221
- 11008 vs. 11000 – 11001, 11010 – 11044
- 19296 vs. 19160, 19162
- 27412 vs. 20926, 27331, 27570
- 29866 vs. 29870 – 29871, 29874 – 29875, 29877, 29884 (same session*) **or**
  29866 vs. 29879, 29885 – 29887 (same compartment*)
- 29867 vs. 27415
- 29867 vs. 27570, 29870 – 29871, 29874 – 29875, 29877, 29884 (same session*) **or**
  29867 vs. 29879, 29885 – 29887 (same compartment*)
- 29868 vs. 29870 – 29871, 29874 – 29875, 29880, 29883 – 29884 (same session*) **or**
  29868 vs. 29881 – 29882 (same compartment*)

***** Documentation is required in the *Remarks* area (Box 19) of the claim to justify a different session and/or different compartment if billing code 29866, 29867 or 29868 with other codes listed.

- 31545/31546 vs. 31540, 31541, 69990
- 31546 vs. 20926
- 32019 vs. 32000 – 32005, 32020, 36000, 36410, 62318 – 62319, 64450, 64470, 64475
- 36475/36476 vs. 36000 – 36005, 36410, 36425, 36478, 36479, 37204, 75894, 76000 – 76003, 76937, 76942, 93970 – 93971
- 36478/36479 vs. 36000 – 36005, 36410, 36425, 36475 – 36476, 37204, 75894, 76000 – 76003, 76937, 76942, 93970 – 93971
- 36818 vs. 36819 – 36821, 36830 (during unilateral upper extremity surgery)
- 36819 vs. 36818, 36820, 36821, 36830 (during unilateral upper extremity surgery)

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

- 43644 vs. 43846, 49320
- 43645 vs. 49320, 43847
- 43845 vs. 43633, 43847, 44130, 49000
- 45391/45392 vs. 45330, 45341 – 45342, 45378, 76872
- 58356 vs. 58100, 58120, 58340, 76700, 76856
- 58956 vs. 49255, 58150, 58180, 58262 – 58263, 58550, 58661, 58700, 58720, 58900, 58925, 58940
- 63050/63051 vs. 22600, 22614, 22840 – 22842, 63001, 63015, 63045, 63048, 63295 (same segments)
- 63295 vs. 22590 – 22614, 22840 – 22844, 63050 – 63051 (same segments)
- 66711 vs. 66990

Reimbursement Restrictions for Select CPT-4 Surgery Codes
The following surgery codes have reimbursement restrictions as noted:

- Codes 19296 – 19298, 29866, 29867, 29868, 31620, 31636, 31637, 31638, 32019, 45391 and 45392 are not reimbursable for assistant surgeon services.
- Codes 36475, 36476, 36478, 36479, 43644, 43645, 43845 and 58956 require prior authorization.
- Codes 37205 – 37208 are Medi-Cal benefits and require prior authorization.
- Code 52402 is reimbursable for males only. This code is not reimbursable for assistant surgeon services.
- Code 57267 is reimbursable for females only.
- Codes 57283 and 58565 are reimbursable only for females 21 years of age or older.

Add-On Codes
The following CPT-4 codes are add-on codes and must be billed on the same claim with the corresponding code for the primary procedure:

Add-On Code	Primary Procedure Code(s)
11008	11004 – 11006
19297	19160 or 19162
31620	31622 – 31638
31637	31636
36476	36475
36479	36478
37206	37205
37208	37207
57267	45560 or 57240 – 57265
63295	63172 – 63173, 63185, 63190 or 63200 – 63290

Note: These add-on codes are not subject to the multiple surgery rate reduction pricing methodology when billed with the primary service code.

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

SURGICAL SERVICES

New HCPCS codes C9718 and C9719 (kyphoplasty) are Medi-Cal benefits.

New HCPCS code G0364 (bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service) is reimbursable to non-physician medical practitioners, but is not reimbursable for assistant surgeon services.

If CPT-4 codes 36818 and 36819 are billed for bilateral upper extremity open arteriovenous anastomoses performed at the same surgical session, providers must bill with modifier -50 (bilateral procedure) or -59 (distinct procedural service), as appropriate.

New CPT-4 codes 37215 (transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection) and 37216 (without distal embolic protection) are Medi-Cal benefits and require prior authorization, subject to the following criteria:

- High-risk patient with symptomatic narrowing of carotid artery of 70 percent or more, **or**
- Patient at high risk for carotid endarectomy that has symptomatic carotid artery stenosis between 50 and 70 percent, **or**
- Asymptomatic high-risk patient with carotid artery stenosis of 80 percent or more.

Codes 37215 and 37216 are limited to providers and facilities that have been determined competent by the Centers for Medicare & Medicaid Services (CMS) to perform the appropriate evaluation, stent procedure and necessary follow-up care. Providers will be required to submit documentation with the claim that the facility is currently on the CMS list of approved facilities.

MEDICINE

Duplicate Payment: Combination Codes

Reimbursement will be made for only one code or set of codes in the following combinations when billed for the same date of service, any provider:

- 92620, 92621 vs. 92506
- 92625 vs. 92562
- 93745 vs. 93741 – 93742
- 93890 – 93893 vs. 93886, 93888

Reimbursement Restrictions for Select Medicine Codes

CPT-4 codes 92620 and 92621 (evaluation of central auditory function, with report) and 92625 (assessment of tinnitus) require prior authorization.

New CPT-4 Transcranial Doppler codes 93890, 93892 and 93893 are limited to four procedures each, per year, and are restricted to the following ICD-9 diagnosis codes: 282.6 – 282.69 (sickle cell disease), 348.8 (other conditions of the brain), 430 (subarachnoid hemorrhage) and 433.00 – 433.91 (occlusion and stenosis of pre-cerebral arteries).

New CPT-4 codes 95928 and 95929 (central motor evoked potential studies) are limited to a total for both codes of four procedures, per year.

2005 ICD-9 Procedure Code Update for Inpatient Providers

New 2005 ICD-9 Procedure Codes
The following new ICD-9-CM Volume 3 procedure codes are effective for dates of service on or after November 1, 2005:

ICD-9 Code	Description
00.16	Pressurized treatment of venous bypass graft (conduit) with pharmaceutical substance
00.17	Infusion of vasopressor agent
00.21	Intravascular imaging of extracranial cerebral vessels
00.22	Intravascular imaging of intrathoracic vessels
00.23	Intravascular imaging of peripheral vessels
00.24	Intravascular imaging of coronary vessels
00.25	Intravascular imaging of renal vessels
00.28	Intravascular imaging, other specified vessel(s)
00.29	Intravascular imaging, unspecified vessel(s)
00.31	Computer assisted surgery with CT/CTA
00.32	Computer assisted surgery with MR/MRA
00.33	Computer assisted surgery with fluoroscopy
00.34	Imageless computer assisted surgery
00.35	Computer assisted surgery with multiple datasets
00.39	Other computer assisted surgery
00.61	Percutaneous angioplasty or atherectomy of precerebral (extracranial)
00.62	Percutaneous angioplasty or atherectomy of intracranial vessel(s)
00.63	Percutaneous insertion of carotid artery stent(s)
00.64	Percutaneous insertion of other precerebral (extracranial) artery stent(s)
00.65	Percutaneous insertion of other intracranial artery stent(s)
00.91	Transplant from live related donor
00.92	Transplant from live non-related donor
00.93	Transplant from cadaver
27.64	Insertion of palatal implant
37.68	Insertion of percutaneous external heart assist device
37.90	Insertion of left atrial appendage device
44.38	Laparoscopic gasteroenterostomy
44.67	Laparoscopic procedures for creation of esophagogastric spincteric competence
44.68	Laparoscopic gastroplasty
44.95	Laparoscopic gastric restrictive procedure
44.96	Laparoscopic revision of gastric restrictive procedure
44.97	Laparoscopic removal of gastric restrictive device(s)
44.98	(Laparoscopic) adjustment of size of adjustable gastric restrictive device
81.65	Vertebroplasty
81.66	Kyphoplasty
84.53	Implantation of internal limb lengthening device with kinetic distraction
84.54	Implantation of other internal limb lengthening device
84.55	Insertion of bone void filler
84.59	Insertion of other spinal devices
84.60	Insertion of spinal disc prosthesis, NOS

Please see **ICD-9 Codes**, *page 5*

ICD-9 Codes *(continued)*

ICD-9 Code	Description
84.61	Insertion of partial spinal disc prosthesis, cervical
84.62	Insertion of total spinal disc prosthesis, cervical
84.63	Insertion of spinal disc prosthesis, thoracic
84.64	Insertion of partial spinal disc prosthesis, lumbosacral
84.65	Insertion of total spinal disc prosthesis, lumbosacral
84.66	Revision or replacement of artificial spinal disc prosthesis, cervical
84.67	Revision or replacement of artificial spinal disc prosthesis, thoracic
84.68	Revision or replacement of artificial spinal disc prosthesis, lumbosacral
84.69	Revision or replacement of artificial spinal disc prosthesis, NOS
86.94	Insertion or replacement of single array neurostimulator pulse generator
86.95	Insertion or replacement of dual array neurostimulator pulse generator
86.96	Insertion or replacement of other neurostimulator pulse generator
89.49	Automatic implantable cardioverter/defibrillator (AICD) check
99.78	Aquapheresis

Revised 2005 ICD-9 Procedure Codes
The following ICD-9-CM Volume 3 procedure codes are revised:

ICD-9 Code	Description
00.55	Insertion of drug-eluting peripheral vessel stent(s)
01.22	Removal of intracranial neurostimulator lead(s)
02.93	Implantation or replacement of intracranial neurostimulator lead(s)
03.93	Implantation or replacement of spinal neurostimulator lead(s)
03.94	Removal of spinal neurostimulator lead(s)
04.92	Implantation or replacement of peripheral neurostimulator lead(s)
04.93	Removal of peripheral neurostimulator lead(s)
36.11	(Aorto)coronary bypass of one coronary artery
36.12	(Aorto)coronary bypass of two coronary arteries
36.13	(Aorto)coronary bypass of three coronary arteries
36.14	(Aorto)coronary bypass of four or more coronary arteries
37.62	Insertion of non-implantable heart assist system
37.63	Repair of heart assist system
37.65	Implant of external heart assist system
37.66	Insertion of implantable heart assist system
39.50	Angioplasty or atherectomy of other non-coronary vessel(s)
39.90	Insertion of non-drug-eluting, peripheral vessel stent(s)
86.05	Incision with removal of foreign body or device for skin and subcutaneous tissue

Conversion of Interim Modifiers and Notice of Public Comment Period

HIPAA mandates that national modifiers replace interim HCPCS modifiers for use in Medi-Cal billing. Effective for dates of service on or after November 1, 2005, interim modifiers -YQ, -YS, -ZK, -ZU and -ZV will be replaced with new national modifiers as indicated below.

A public comment period is ongoing until September 30, 2005. (See below for more details.) Absent any grave concerns arising from the public comments, the Department of Health Services (DHS) will proceed with the modifier changes listed below. The policy of the interim modifier applies to the replacement modifier.

Please see **Modifiers**, *page 6*

Modifiers *(continued)*

Interim Modifier	Replacement National Modifier
-YQ (Certified nurse midwife service)	-SB (Nurse midwife)
-YS (Nurse practitioner service)	-SA (Nurse practitioner with physician)
-ZK (Primary surgeon)	-AG (Primary surgeon)
-ZU (Exception modifier to 80 percent reimbursement [medical necessity; outpatient setting])	**Two modifiers required:** -22 (Unusual procedural services) **and** -SC (Medically necessary service/supply) **and** Facility Type Code 13 or 83 **or** Facility Type Code 14 **plus** Frequency Code 1
-ZV (Exception modifier to 80 percent reimbursement [non-hospital compensated physician; emergency service])	**Three modifiers required:** -22 (Unusual procedural services) -SC (Medically necessary service/supply) -ET (Emergency services)

Note: When billing for the exception to 80 percent reimbursement, modifier -22 must be the first modifier listed on both the *Treatment Authorization Request* and claim form in order for the claim to reimburse correctly.

Comment Period

Notice is hereby given that DHS will conduct written public proceedings, during which time any interested person or such person's duly authorized representative may present statements, arguments or contentions (hereafter referred to as "comments") relevant to the action described in this notice.

Comments must be received by DHS by 5 p.m. on September 30, 2005, which is hereby designated as the close of the written comment period. All written comments to DHS, including e-mail, mail or fax transmissions, must include the author's name, organization or affiliation and telephone number.

Comment Instructions

The Medi-Cal Comment Forum page includes links for e-mail comments by "Providers," "Medi-Cal Managed Care Plans" or "General Public." The "Medi-Cal Comment Forum" page is located in the HIPAA News section on the Medi-Cal Web site (**www.medi-cal.ca.gov**). Providers should select the "Medi-Cal Comment Forum" link, enter comments in the body of the e-mail and send it to the pre-formatted address in the "To:" line.

Note: E-mail is not confidential, so users should be cautious when entering confidential or sensitive information. Email addresses will not be shared with outside parties, but may be used for future DHS mailings.

Comments may also be submitted by mail or fax to:

Medi-Cal Comment Forum
P.O. Box 13811
Sacramento, CA 95853
Fax: (916) 638-8976

All written comments to DHS, including e-mail, mail or fax transmissions, must include the author's name, organization or affiliation and telephone number.

Health plans are requested to centralize their comments and send them to DHS through their designated HIPAA contact person.

Valid Delay Reason Code Necessary When Billing CCS Inpatient Claims After 6-Month Time Limit

California Children's Services (CCS) providers who submit inpatient claims as an exception to the six-month billing time limit are reminded that they must include a valid delay reason code to be processed for full Medi-Cal payment. Payments to providers who submit CCS claims after the six-month billing time limit without the required delay reason code will be reduced in accordance with Medi-Cal policy.

Refer to the *Claim Submission and Timeliness Overview* section in the Part 1 manual for more information about delay codes and reimbursement reduction for late claims. The *UB-92 Completion: Inpatient Services* section of the Part 2 manual contains a list of valid delay reason codes.

This information is reflected on manual replacement page cal child bil 2 (Part 2).

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claims Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal has established a plan to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claim transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Medi-Cal now offers Computer Media Claims (CMC) filing using the ASC X12N 837 4010A1 transaction format. Acceptable media submission types are dial-up, tape or Internet. CMC and paper claims must meet the same billing requirements according to Medi-Cal policy.

Information for 837 Transaction Applicants
The "HIPAA Update" and "HIPAA News" pages on the Medi-Cal Web site include links to a number of Web pages with important information for 837 transaction submitters and applicants, including technical specifications, implementation instructions, user guides, frequently asked questions (FAQs) and biller updates.

Application/Agreement Form
Providers may submit 837 transactions directly or employ a billing service to prepare and submit their 837 transactions. To become an authorized 837 transactions submitter, providers and billing services must first complete, sign and mail an application/agreement available on the Medi-Cal Web site at **www.medi-cal.ca.gov**. From the home page, click "HIPAA," then "Electronic Transactions: Biller Updates," "Computer Media Claims Enrollment and Testing Procedures for 837 4010A1 Transactions," then "*Medi-Cal Telecommunications Provider and Biller Application/Agreement*." The form is also found after the *CMC Enrollment Procedures* section in the Part 1 manual.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: cal child bil 1/2